VERMONT

DOL FORM 10/10s (Rev. 5/05)

State File No. _____

Ins. Co. File No. _____

Date of Injury _____

Fed. ID No. _____

DEPARTMENT OF LABOR
WORKERS' COMPENSATION DIVISION

CERTIFICATE OF DEPENDENCY AND EMPLOYEE EXEMPTION REPORT

EMPLOYEE: _____ SOCIAL SECURITY NO.: _____

EMPLOYER: _____

TO THE EMPLOYEE: This form MUST be completed in every workers' compensation case in which an injured worker has lost time from work as the result of a work-related injury. The form must be completed even when the injured worker has no dependents. The information must be supplied and the form signed by the injured worker. This information is required by the Department of Labor to determine the employee's right to additional weekly compensation of $10.00 for each dependent child under the age of twenty-one (21) years.

PART A:

FILING STATUS – Select One: [For purposes of determining Earned Income Credit (EIC)]

☐ Single ☐ Married or Civil Union

PART B:

List below your dependent child(ren) that have not already been declared by your spouse or reciprocal beneficiary on his/her current workers' compensation claim, the child's date of birth, and their relationship to you.

	NAME OF DEPENDENT	DATE OF BIRTH	RELATIONSHIP
1.			
2.			
3.			
4.			
5.			

I HEREBY CERTIFY that the above is a true, complete and accurate statement of my dependents.

_____ _____

Employee Signature Address

_____ _____

Telephone Number City/State